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THE BAMAKO INITIATIVE

Interim progress report

SUMMARY

The present report is presented at the request of the Bureau. Although the Bureau recognized Executive Board decision 1992/22 (E/ICEF/1992/14), which called for, inter alia, a progress report on the implementation of the Bamako Initiative in 1994, it nevertheless determined that an update on the Initiative at the 1993 regular session of the Executive Board would serve to maintain an appropriate focus on the UNICEF priority for Africa. The report discusses key aspects of the Initiative in the evolving political context of Africa, emphasizing the role of the household in reaching significant changes in health behaviour and status. The report focuses on countries that have taken up the Initiative in the last year.

Given the experience gained thus far and the positive assessments that have been made of its implementation, an acceleration of the Initiative is now possible. Acceleration, however, will depend upon a much broader mobilization of financial resources, provided either directly or through UNICEF, implying the need to move faster towards consolidating a wide donor alliance in support of the Initiative.

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INTRODUCTION

1. Although the Executive Board decided at its 1992 session that a further progress report on the Bamako Initiative should be presented to the Executive Board at its 1994 regular session (E/ICEF/1992/14, decision 1992/22), the Bureau requested that an interim report be presented to the Executive Board at its 1993 regular session to ensure continued UNICEF focus on both Africa and on the Initiative itself. This is particularly pertinent after the Organization of African Unity International Conference on assistance to the African child, held in November 1992, which, through the "Consensus of Dakar" and the report of the working committee on health, has re-emphasized the importance of strengthening district-level health systems and has indicated the Bamako Initiative as a successful undertaking in the co-management and cost-sharing of health services between Governments and communities.

2. Briefer than a full progress report, this interim report highlights the diversity of action supported by UNICEF and other donors, action which is gradually becoming a global movement towards community-focused health sector development. The report also includes a brief description of follow-up action taken in accordance with the recommendations made in the evaluation of the Bamako Initiative carried out by the London School of Hygiene and Tropical Medicine and presented to the 1992 Executive Board (E/ICEF/1992/L.20). Finally, it summarizes the action in a number of countries which have newly begun to implement the Initiative. Some of these countries are in Asia, Latin America and the Middle East, where the principles of the Initiative are increasingly being adopted for the revitalization of health systems affected by prolonged economic crisis and by the transition from centrally planned to market economies.

I. THE BAMAKO INITIATIVE AND THE EVOLVING POLITICAL CONTEXT

3. On the African continent, as elsewhere in the developing world and in Eastern Europe, centralized systems of Government are being challenged. As many as 20 African countries are either "in transition" towards a democratically-based Government or have substantial popular movements challenging the existing centralized Governments that have demonstrated their inability to sustain the provision of basic services.

4. Within the health sector, there is a strong push for a private, uncontrolled, health care market. Typically, however, private, for-profit health services have developed unevenly, offering services only in or close to major population centres. Moreover, even where they exist, private services are often only accessible to the population with higher income, and there is limited quality control with respect to the services being provided.

5. In this context, the Bamako Initiative offers a promising alternative to the traditional mixture of public and private services. It is an alternative which, like the private sector, demands efficiency in order to be competitive and sustainable, but which stands squarely in the public sector, characterized by greater accountability to users through their direct control and co-management of resources and by concern for equity. The Bamako Initiative is

also proving to be more affordable than both the private offer of services and the present public offer, which is often incomplete and forces users to "shop around" for key inputs to care, such as drugs.

6. As Governments move away from central level control over the management of health services, especially in the provinces and the periphery, communities are in a stronger position to influence the functioning of their local health facilities according to local conditions and demands. The clearest manifestation of this stronger community position is their increased influence through their demand and payment for services. The Initiative, by placing emphasis on the local retention and management of resources through a partnership between providers and users, has acknowledged and supported this process of decentralization to make health service delivery more effective and more responsive to the needs of the population.

7. In a number of countries, the Bamako Initiative was discussed during the debates of the national conferences on constitutional reforms and has deeply influenced the revision of national health strategies. In the Congo, for example, the national conference agreed on a multi-party system and recommended that the transitional Government adopt a new national health plan based on the Bamako Initiative. The new plan was signed into law in April 1992.

8. Major shifts in health policy, however, have not been the norm in most of the countries, and there is still a slowness in translating the fundamental changes that are taking place in African societies into changes in the health sector. As reported last year, although community action is very decisive, national Governments, even when faced with positive results, often seem to resist the necessary changes in policy and resource allocation. In some quarters, there is still hope that the Initiative can be used as an "add-on" to what already exists, rather than being a shift in orientation to community-driven action based on local decision-making.

9. Significant reform is required in the health sector in order to place due priority on the provision of a set of basic services that addresses the main causes of mortality in children and mothers. Without this, and the commitment to an adequately functioning peripheral health care system as a necessary condition for providing such services, the child health goals of the 1990s will not be reached. With six significant intermediate health and nutrition targets for 1995 adopted through the "Consensus of Dakar", the urgency to strengthen and extend this system in every country in Africa is heightened. Following the recognition in the evaluation of the London School of Hygiene and Tropical Medicine that the Bamako Initiative is "an appropriate path towards the development of primary health care" (E/ICEF/1992/L.20, para. 75), the main challenge through mid-decade is the consolidation and extension of the Initiative to all health facilities in Africa.

II. CONSOLIDATION OF THE INITIATIVE AT HOUSEHOLD AND DISTRICT LEVELS

10. The health of a population, like its nutritional status, is the final "outcome" of social, behavioural, political and environmental conditions. As the multi-donor evaluation of UNICEF (see E/ICEF/1993/CRP.7) has pointed out in its health and nutrition analysis, strategies in health need to take into

account the immediate causes, the underlying causes and the structural/basic causes of ill health. These strategies are best defined in terms of an appropriate mixture of technical interventions, health systems development and multi-sector empowerment programmes. Improving child health requires the involvement of all sectors of society, including political leaders, religious authorities, the private sector, community groups and households. The health sector cannot be left wholly - or even primarily - responsible for ensuring the health of a given population, but it is responsible for ensuring access to adequately functioning health care services that deliver well-defined technical interventions, and it is an important partner in multi-sector empowerment programmes that address structural change. Thus, the Bamako Initiative has emphasized the need to ensure that health services provide a basic package of priority services which address the major local causes of morbidity and mortality, implying having a steady supply of essential drugs and supplies; increasing the capacity of health personnel in terms of diagnostic and treatment practices; and applying appropriate technical standards and managerial practices, including effective monitoring.

11. At the same time, the Initiative recognizes that health systems cannot be strengthened in isolation from the population and the society at large. Thus, stress is placed on community co-management of resources, including cost-sharing, financial management and quality control. Community co-management of resources, which improves the accountability of the health system to the communities served, is typically done through management committees. Thus, the Initiative promotes the direct involvement of communities and households in the running of their health services and, through increased interaction with the health staff, increases their capacity to undertake appropriate preventive and curative actions at household and community levels.

12. Most of the countries that have embarked on the Initiative began by focusing on the functioning of the health centres, both because of their relative proximity to the communities and because of their potential effectiveness in providing appropriate care for the population in their area. It was also assumed - and confirmed by experience - that utilization of health centres depends on achieving and maintaining an acceptable quality of care. Significant emphasis was, therefore, placed on ensuring a minimum set of quality services, covering both preventive and basic curative care, entailing the training of staff as well as the introduction of new systems of management. To support this, UNICEF has been an active partner in formulating the manuals used in management, such as the manual recently issued by the Federal Ministry of Health in Nigeria. UNICEF has also pioneered a newsletter for health workers, "The Prescriber", initially in cooperation with The United States Pharmacopeial Convention, Inc., and now with Association mieux prescrire and in consultation with specific World Health Organization (WHO) programmes. This newsletter is issued in English, French, Spanish and Portuguese to 35,000 health workers world wide, with distribution increasing at a rapid rate. In many countries, it appears to be the only information note received by health workers.

13. It is imperative that the role of the household in decisions either conducive to or detrimental to the health status of children and women be fully recognized. The recognition of this role is clearly necessary with regard to reproductive health and the prevention of acquired immune deficiency syndrome, but no less important in the control of simple diseases. For example,

home-based action is critical for acute watery diarrhoea, which still accounts for 80 per cent of all diarrhoea cases and 50 per cent of all deaths due to diarrhoea. Similarly, the ability of caretakers to recognize signs of serious illness will significantly affect the survival of children with pneumonia.

14. Community-based research has shown that health personnel are an important source of information and advice to households on health action, whether home-based or facility-based. Therefore, in consolidating and furthering achievements to date, greater emphasis is being placed on ensuring that community representatives - women, in particular - are included in key decision-making processes; promoting greater interaction and information exchange between providers and households; and encouraging health providers to participate and provide support to community action taken in pursuit of better health. Now that health centre committees in many countries have gained confidence in their ability to manage the financial aspects of health centres, there is increasing focus on strengthening the population's own capacity to monitor its health and nutrition situation and, with the support of health staff when necessary, to take appropriate action.

15. Traditionally, health workers were considered to be the only people with the technical competence to monitor the health situation of the population. Experience, however, both within the Bamako Initiative and elsewhere, has made it clear that monitoring begins at the community level. Health staff can play a strategic role by providing support in systematizing the local collection and analysis of information. As part of the Initiative, Kenya and Benin have established community-based information systems that are serving as excellent means of raising awareness and sharing information between the population and the health staff. The routine collection and analysis of data on child and maternal deaths, births, immunization coverage and the incidence of one or more major diseases stimulates local-level action and, when shared with the health care system, helps to focus health centre resources on priority needs. Thus, reductions in child and maternal mortality are the result of cooperative efforts between the people and the health care providers.

16. In health centres where the Bamako Initiative components are in place, the quality of care has improved and the utilization of services has increased. A major challenge that now can be addressed is the improved functioning of the first level of referral, the district hospital. This is of particular importance, especially in countries where the rate of maternal mortality is high. No amount of antenatal care can be of help if a woman is in need of a Caesarean section. One part of the challenge entails strengthening the links between the peripheral health units and the district hospital, making it part of the same system and thus ensuring continuity of care. The other is to revitalize the district hospitals, many of which are presently operating like large health centres and using their resources inefficiently.

17. Thus, the experience in revitalizing health centres is being broadened to consolidate achievements made so far, while making greater progress in household- and community-level action, as well as at the district hospital, in order to truly strengthen district health care management. Particular attention is being placed on the control and management of resources, which has played a key role in the revitalization effort thus far. During 1992, work on both of these issues - the empowerment of communities and the district hospital - was

further developed through two workshops initiated by UNICEF as a specific follow-up to the recommendations made in the evaluation of the London School of Hygiene and Tropical Medicine, as was a similar workshop on quality of care issues. At present, work is also being carried out to take a much closer look at the situation of health personnel.

18. In different ways, and at different paces, the process of consolidation proceeds in the 18 countries listed as "core" in the 1992 progress report on the Bamako Initiative (E/ICEF/1992/L.22). Among these countries (namely, Benin, Burundi, Cameroon, Central African Republic, Congo, Ghana, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Togo and Zambia), five are presenting country programme recommendations to the Executive Board at its 1993 session, with the Bamako Initiative featured as the health strategy. In Burundi (E/ICEF/1993/P/L.4) and Rwanda (E/ICEF/1993/P/L.5), the new programmes aim at an extension of the Initiative to the national level. Significant extension, in collaboration with other donors, is also envisioned in the new programmes being presented for the Central African Republic (E/ICEF/1993/P/L.6), Mali (E/ICEF/1993/P/L.7) and Mauritania (E/ICEF/1993/P/L.8).

III. COUNTRY ACTION

19. In the past year, country action has increased to cover almost all African countries, either in direct implementation or in preparatory activities. In sub-Saharan Africa, the number of core countries has increased from 18 to 22, with Equatorial Guinea, Gambia, Lesotho and Madagascar joining the list in 1992. In addition, there are three countries outside Africa – Peru, Myanmar and Viet Nam – where the Bamako Initiative is well established, bringing the total number of participating countries to 25. There is also increased interest and, in some cases, preparatory activities, in a number of additional countries within Africa, as well as in countries in Asia and Latin America. This interim report will focus on the countries that have begun to implement the Bamako Initiative in the past year and on those which have made significant progress towards adoption of the Initiative.

A. Expansion within Africa

20. Preparatory action began in Burkina Faso with a workshop to define the minimum package of health services to be delivered at each level, the role of the health district, community involvement, the steps needed to introduce the community control of revenue and the start-up period for the Initiative. With the support of the World Bank and the German Agency for Technical Cooperation (GTZ), a national drugs policy and accompanying legislation have been prepared. The conditions for the creation of a central procurement agency for generic-name essential drugs have been established. With the support of United States Agency for International Development (USAID), French and Italian bilateral cooperation and UNICEF, action in 20 health centres is under way as of 1993. The Initiative is included in the Burkina Faso country programme recommendation (E/ICEF/1993/P/L.25) being presented to the Executive Board at its 1993 session.

21. Considerable progress has been made towards the adoption of the Bamako Initiative in Cape Verde, after a July 1992 meeting of the Ministry of Health, WHO and UNICEF. A memorandum signed at the end of the meeting reflected weaknesses in the present health system and suggested solutions in line with the Initiative. The country has a well-established essential drugs policy, with an emphasis on generic-name products, and communities are already involved in financing basic health care; the next steps are to create a national task force for planning action and to review different options for the introduction of community co-management.

22. The Initiative was formally introduced in nine health zones of Kelo district in Chad during 1992, with the central Government agreeing to the community management of revenue, following similar experiences supported by non-governmental organizations (NGOs) and the United Nations Development Programme. Supervisory roles have been defined at primary, district and national levels, and all essential inputs were provided for start-up. Key staff of the Ministry of Health benefited from visiting the Initiative in Benin.

23. The Ministry of Health in the Côte d'Ivoire elaborated a national plan of action for putting the Bamako Initiative into practice through the end of the decade. Subsequently, several directives have been issued to orient the work to be undertaken, and training manuals for health centre staff have been prepared. It is expected that an initial 18 centres will become operational at the beginning of 1993.

24. An initial assessment of the relevance of the Initiative has taken place in Djibouti, where the per capita consumption of drugs has been estimated by WHO at $12 per person per year, a large proportion of which is spent on brand-name drugs. Introducing an essential drugs policy based on generic-name drugs would increase the affordability of drugs generally and attract local financing from a wider population base.

25. Two districts in Equatorial Guinea, Baney on the island and Bata on the mainland, involving 37 villages, have begun to implement the Initiative through the increased availability of drugs and impregnated mosquito nets based on community-managed funding. The approval of an essential drugs list, the preparation of a diagnostic guide and management tools and staff training have all facilitated the first phase of implementation. By 1993, 6 of the 27 health centres in the country will be fully operational in support of the Initiative, including outreach to the village level.

26. Final preparations have been made to start-up the Initiative in two districts of the Gambia, Farafenni and Gambissara. A 10-person, multisectoral team visited Guinea in mid-1992 to gain first-hand experience of implementation issues, leading to a decision to take the health facility as the focal point for action in the Gambia, the alignment of primary health care (PHC) villages to the catchment areas of basic health facilities and the preparation of a work plan for the two districts to start activities in 1993.

27. In late 1991, the Government of Lesotho committed itself to the implementation of the Initiative, renewing the national task force that had been formed earlier and expanding it into an intersectoral group with all interests represented. An executive committee oversees operations, which have started in

five health service areas. Guidelines for action at central health service area and community levels have been produced along with a training guide. The Initiative is gaining considerable acceptance, and it is predicted that there is scope for rapid expansion to other health service areas over the next two years.

28. The Initiative was finally adopted in Madagascar in April 1992, as a strategy for health relevant to the political, social and economic restructuring taking place in the country. A national steering committee was formed to coordinate action, and baseline studies on community financing were started. A national workshop sponsored by WHO in July 1992 served to officially launch the Initiative. Initially, six health centres in the province of Tamatave have been identified for start-up in 1993. Community mobilization has begun and training modules, a diagnostic guide and monitoring tools have been prepared.

29. In 1992, the Government of Malawi, recognizing the deteriorating state of health services and severe budgetary constraints, for the first time accepted the idea of community financing of PHC. NGO experience with small-scale community financing projects will provide some pointers for increasing local capacity in the Initiative.

30. A first step in addressing the Initiative in Mozambique will focus on a district-level costing exercise of health services, following experiences that took place in Zambia and Burundi in 1992, with technical guidance from the London School of Hygiene and Tropical Medicine. This is seen as a key activity in 1993, with a view to addressing the issues of decentralized management and sustainability of recurrent costs.

31. The Government of Namibia included the Bamako Initiative in the "National primary health care - community-based health care guidelines", launched in February 1992. Since then, both WHO and UNICEF have been active in supporting planning workshops at national, regional and local levels, focusing on decentralization and operational issues in delivering local health services. The retention of a proportion of user fees at the local level is a specific recommendation that came from these workshops, and it is expected that specific guidelines for action in financing and community involvement will be forthcoming in 1993.

32. Preparatory work on the Initiative began in the Niger during 1992, with considerable attention paid to baseline surveys for providing an accurate assessment of peoples' knowledge and practices in health. A restructuring of the National Office for Pharmaceutical and Chemical Products, supported by the European Community, is under way in order to improve the drugs management system. In 1993, UNICEF will initiate specific support to the districts of Aguie, Madarounfa, Mayahi and Tessaoua, as well as to the Boubon area close to Niamey, leading to start-up in 4 medical centres and 13 rural dispensaries, from which experience for future expansion will be gained. The World Bank, USAID and French and Belgian bilateral cooperation are also associated with the work taking place.

33. Recent developments in the Sudan have improved the conditions necessary for implementation of the Bamako Initiative. These include the adoption of the health area system with specific catchment areas, decentralization of many government functions and the establishment of advisory and steering committees.

Specifically, in Kordofan, which is the area of concentration of the Initiative, steering and coordination committees have been formed within the state, health areas and communities, and community-level joint planning and decision-making with health workers is being encouraged. UNICEF has supported six health areas with essential drugs and funds for training and technical assistance. The World Bank has also been active in providing a $1 million loan in support of community pharmacies in Kordofan and Darfur States. For the immediate future, the development of government policy on community participation and cost-sharing will be crucial in order for the Initiative to take a firmer hold.

34. Uganda has undergone important political changes, entailing a major shift towards decentralization. The reform calls for the devolution of decision-making powers, funds and responsibility from the central level to the districts. This devolution will effectively strengthen the elected district authorities and confine the central ministries to the role of standard-setting, quality control, monitoring and district support. All central ministries have been asked to prepare position papers defining their role and to practically assess the national consequences of downsizing. In health, these developments will accelerate the national capacity-building effort for sustainable PHC, which is assessing appropriate structures for community participation and strategies already being applied.

35. The Government of Zimbabwe is giving considerable attention to the Bamako Initiative, together with the World Bank, WHO, UNICEF and the Overseas Development Administration (United Kingdom of Great Britain and Northern Ireland) on health financing issues, given that the financial situation of the country's health care system is becoming increasingly precarious. UNICEF has sponsored a study to assess the impact of user fees on equity, morbidity and mortality and the administration of the health care system, with the aim of focusing on issues such as community involvement in financing and management, reform of the essential drug management system and cost containment measures, rather than just on user fees.

B. Expansion beyond Africa

36. It should be recognized that, as an African initiative, the focus of the Bamako Initiative is still strongly on Africa, given that this continent is doubly handicapped by collapsing public sector health care delivery systems, together with low coverage of these systems, even when they are fully functioning. Access to health facilities in regions other than in Africa is generally greater; thus, in those regions, the revitalization of the existing infrastructure is the principal aim.

37. In 1991, Peru began a programme to revitalize peripheral health services with community participation. Thus far, the programme has concentrated on improving the quality of health care through the creation of community pharmacies, managed jointly by the health services and the community. By the end of 1992, 59 health centres and posts in the cities of Lima and Chimbote had established such pharmacies with joint management committees, benefiting over 210,000 people of limited income. Apart from providing greater access to low-cost essential drugs, this effort is intended to stimulate the development

of a national essential drug policy. In 1993, an extension to three other regions of the country is planned.

38. Although health care is officially "free" in Myanmar, patients are obliged to bear a portion or, more often, all of the costs of medical treatment. The National Health Committee, the country's top health policy-making body, having endorsed decentralized management through the formation of township, ward and village health committees, is showing greater interest in introducing a more systematic approach to community cost-sharing, and has called for nationwide implementation of local initiatives where possible. Advocacy meetings with health staff, general practitioners and local administrative authorities have been held to initiate the process. Studies on health and financing have been carried out in order to gain better insight into the local situation. Implementation has begun in pilot areas and is expected to be extended in 1993.

39. In Nepal, an in-depth study of behaviour and practices, especially in the use of health facilities and drugs, has been completed. A high-level task force, headed by the Secretary of the Ministry of Health, has been formed to develop a plan of action for revitalizing peripheral health facilities, initially in five districts. The plan is based on the findings of the study, on the situation analysis of the districts and on an in-depth study of existing drugs schemes in the country. Although a standard essential drugs list and standard supply and equipment lists for facilities have been formulated, and a draft guideline on local financing has been prepared, delays in the preparation of the action plan have occurred due to a major reorganization taking place in the Ministry of Health. It is predicted, nevertheless, that implementation in the districts will begin in early 1993. A new development has been the decision to create 3,199 sub-health posts in the country by 1997 in order to increase access to health care. For this, resource mobilization through community participation in co-financing schemes will be encouraged.

40. Implementation of the Initiative has already reached 251 commune health centres in Viet Nam. The initial emphasis has been to open financially viable and continuously stocked pharmacies in the health centres, which are run by the peoples' committees. Funds generated have allowed for the re-stocking of drugs from district or provincial stores, as well as for paying local operating costs and small incentives to health workers. Both management and drug prescribing practices need to be improved so that the focus is more on health, rather than just on drugs. In 1992, the Bamako Initiative approach was recognized as relevant to the Ministry of Health's priority programme for strengthening the PHC network; presently, there is a move towards redirecting this programme to a more community-oriented management system. Since there is potential donor support for this national programme, there is a real possibility for expanding the Initiative rapidly.

41. Health services in Yemen have been seriously affected by the economic crisis of the last two years, and only a total reform and adoption of alternative approaches can begin to address a revitalization of the health system. An outline of a community-financed health strategy has been prepared and its feasibility will be tested in 1993. The possibility of community financing of health care has also been studied in Ecuador. Although no specific action has been taken, the new Government has made the availability of generic-name drugs one of the central points of its health policy, and this will

facilitate the move towards the local financing of health care. Some districts in the Lao People's Democratic Republic have experience in revolving drugs funds with the support of NGOs, and this experience has promoted interest from the Government in the community financing and management of health services. In addition, Bangladesh, Cambodia, Honduras, Mongolia and Pakistan have also expressed their interest in exploring the relevance of the Bamako Initiative approach to their own situations.

IV. RESOURCES

42. The emergency situation in the health sectors in many of the developing countries has not yet become a "loud" emergency, like famine or war. However, if the health services are allowed to remain in their present condition, or worse, to further deteriorate, the emergency will become increasingly drastic, with significant negative impact on the mortality and morbidity of women and children. In its action to support the revitalization of health services through the Bamako Initiative, UNICEF has continued to depend largely on the mobilization of general resources. Little supplementary funds were received in 1992, with the exception of two important contributions made at the end of the year: $2.6 million from the Government of the Netherlands ($1.6 million for Kenya and $1.0 million for Guinea-Bissau); and $800,000 from the Government of the United Kingdom ($600,000 for Nigeria and $200,000 to support research on the question of equity).

43. The situation in 1993 will become critical, since general resource allocations are relatively limited and more and more countries will adhere to the principles of the Initiative or accelerate action as a fundamental step in reaching the health goals for the 1990s. There is a need for the donor community to join together more forcefully in supporting the Initiative, either directly or through UNICEF.

Table 1. UNICEF investment in the Bamako Initiative: Bamako Initiative development fund, 1988-1996

(In thousands of United States dollars)

Year	Funded	Unfunded	Total
1988	250	-	250
1989	7 181	687	7 868
1990	5 952	3 096	9 048
1991	22 225	15 307	37 532
1992	22 514	9 662	32 176
1993	11 737	16 932	28 669
1994	9 538	12 504	22 042
1995	5 437	7 725	13 162
1996	1 215	2 971	4 186
Total	86 049	68 884	154 933

Table 2. UNICEF investment in the Bamako Initiative (funded)

(In thousands of United States dollars)

Country	1992	1993	1994	1995	1996	Total
Benin	491	85	85	-	-	661
Burkina Faso	250	-	-	-	-	250
Burundi	820	-	-	-	-	820
Cameroon	783	297	255	255	-	1 590
Central African Republic	200	-	-	-	-	200
Chad	204	-	-	-	-	204
Congo	933	293	295	336	437	2 294
Côte d'Ivoire	598	400	406	400	330	2 134
Gambia	50	50	100	100	200	500
Ghana	184	425	432	440	-	1 481
Guinea	2 267	780	730	730	-	4 507
Guinea-Bissau	1 120	65	-	-	-	1 185
Kenya	3 284	524	-	-	-	3 808
Lesotho	218	66	56	30	56	426
Madagascar	160	260	-	-	-	420
Mauritania	290	124	-	-	-	414
Myanmar	180	-	-	-	-	180
Nigeria	4 242	2 647	1 847	1 909	-	10 645
Peru	-	70	70	70	-	210
Rwanda	600	600	600	-	-	1 800
Sao Tome and Principe	160	190	150	150	-	650
Senegal	102	282	192	192	192	960
Sierra Leone	1 850	765	770	745	-	4 130
Togo	991	470	470	-	-	1 931
Zambia	454	344	80	80	-	958
Subtotal	20 431	8 737	6 538	5 437	1 215	42 358
Global						
Country unallocated	0	700	600	-	-	1 300
Advocacy	38	357	348	-	-	743
Technical support	845	643	652	-	-	2 140
Bamako Initiative Management Unit	1 200	1 300	1 400	-	-	3 900
Subtotal	2 083	3 000	3 000	-	-	8 083
Total	22 514	11 737	9 538	5 437	1 215	52 441

Table 3. UNICEF investment in the Bamako Initiative (unfunded)

(In thousands of United States dollars)

Country	1992	1993	1994	1995	1996	Total
Benin	313	750	-	-	-	1 063
Burundi	2 460	3 010	-	-	-	5 470
Cameroon	-	901	409	315	-	1 625
Congo	197	274	328	417	511	1 727
Côte d'Ivoire	505	721	799	865	747	3 637
Gambia	140	290	350	410	385	1 575
Ghana	234	675	721	547	-	2 177
Guinea	188	1 325	1 310	870	-	3 693
Kenya	-	1 085	-	-	-	1 085
Lesotho	53	100	100	-	-	253
Nigeria	-	1 583	2 045	1 845	-	5 473
Peru	-	805	435	190	70	1 500
Rwanda	2 956	2 976	2 528	-	-	8 460
Sao Tome and Principe	40	10	50	50	-	150
Senegal	872	842	1 174	1 211	1 258	5 357
Sierra Leone	1 175	1 400	923	700	-	4 198
Togo	389	1 158	994	-	-	2 541
Zambia	140	112	338	305	-	895
Total	9 662	16 932	12 504	7 725	2 971	49 794

V. ACCELERATION OF IMPLEMENTATION

44. In the first five years, many countries demonstrated their ability to revitalize public sector health facilities, particularly peripheral health care units (dispensaries, health posts, health centres), by applying the principles of the Bamako Initiative. There is an urgent need now to accelerate implementation to cover the majority of existing units, together with the provision of adequate support from district health teams and appropriate referral services to the district hospital, as well as outreach services to those outside of the facilities' catchment areas.

45. At present, UNICEF is actively supporting approximately 5 per cent of the peripheral health care units in sub-Saharan Africa under the Initiative; other donors may be supporting between 2 and 3 per cent. Assuming external support is provided to each unit for an average of four years (one year of preparation and three years of decreasing inputs) and the present level of resources is maintained, it would take nearly 40 years to cover all of the existing 40,000 peripheral health care units. Even then, close to 50 per cent of the population living outside the range of existing facilities would lack access. Clearly, a new era of action will be required in the upcoming years to effectively establish a sustainable basic health care system in every country.

46. The Initiative is well established in a core group of 22 countries in Africa. The opportunity exists for going-to-scale quickly in several of them,

namely, Benin, Burundi, Cameroon, the Congo, Equatorial Guinea, the Gambia, Guinea, Rwanda and Sao Tome and Principe. With utilization rates of between 0.3 and 0.5 visits per person per year in many units, acceleration of implementation will mean not only rapidly increasing the number of units revitalized, but also increasing utilization by improving the quality of care and carrying out effective outreach services. Apart from the nine countries able to consider rapid acceleration, the other 13 African countries of the core group have good prospects for moving forward. In addition, three larger countries that have not yet adopted the Initiative, namely, Ethiopia, Mozambique and the United Republic of Tanzania, are beginning to address the deteriorating situation of their health services. As noted above, preliminary assessments have already been made in other countries, such as in Zimbabwe.

47. The acceleration of implementation will need to be based on a number of strategic actions, both country-specific and generic in nature, which, together with country-specific implementation, will form the basis for UNICEF support in the period through mid-decade:

(a) A more detailed assessment, country-by-country, of the present level of action benefiting from UNICEF support as well as from support from other donors. This should lead to a specific plan which includes the setting of targets to be reached initially by end-1995 in terms of the peripheral health care units and the population to be covered, services to be delivered, resources to be mobilized, technical assistance required and donor involvement expected;

(b) Continued support to health sector reform following the eight guiding principles of the Bamako Initiative. Specific attention will be given to reviewing not only the contents, but also the means to apply policy improvement in health sector financing, such as more efficient use of resources in the peripheral health system; the establishment of norms for co-management; appropriate mechanisms to ensure access to services for the poor; and the provision of essential drugs under generic names, in order to provide the most affordable and appropriate drugs to the people;

(c) Increased attention to human resources development of key government staff and local leaders. This will apply as well to managers and the health staff from UNICEF and other donor agencies. Increased exchange between countries on key issues is one area of consideration, involving both government officials as well as academic leaders;

(d) Research into key topics through the establishment of long-term research projects, linking academic institutions in donor countries to similar institutions and ministries of health in African countries. The evaluation carried out by the London School of Hygiene and Tropical Medicine, which was endorsed by the Executive Board (E/ICEF/1992/14, decision 1992/22), highlighted capacity-building at lower levels of Government, quality of care, affordability, pricing structures and payment mechanisms, cost recovery, pricing, equity and community organization as areas requiring more attention. At its 1992 regular session, the Executive Board itself stressed the importance of equity, alternative financing mechanisms and the capacity of local populations as particular areas in which UNICEF should undertake specific operations research;

(e) Development of a package of management tools that is readily available for adaptation to each country in order to facilitate start-up action at health care unit and district levels.

VI. PARTNERS

48. Resource mobilization for the acceleration of the Initiative in sub-Saharan Africa will necessarily involve other partners taking up the Initiative in a broader way than before, either by channelling funds through UNICEF or by providing their resources directly. Funds through UNICEF have been received or are forthcoming from the Governments of the Netherlands, Nigeria (for re-investment in Nigeria), Norway and the United Kingdom, as well as from UNICEF National Committees, notably, those in Italy and Canada. Some direct bilateral assistance from Belgium, France, Germany, the Netherlands and Switzerland, as well as financing from the European Community, have been directed to the Initiative.

49. Greater linkage with the World Bank, not only on the policy review of better health in Africa, but in co-financing as well, has increased the potential for mobilizing resources for the Initiative. In Mali, for example, the Bamako Initiative principles are the basis of the new health sector policy; the primary vehicle for its implementation is the World Bank's health sector loan in which UNICEF, USAID, the European Community, the German Bank for Reconstruction and French bilateral assistance are all active partners of the World Bank and the Government of Mali. A key role played by UNICEF has been to recruit health advisers to work in each of the five regions covered by the project in order to strengthen the regional and district planning and implementation capacity and to ensure that sufficient attention is given to the involvement of communities in this revitalization effort. Co-financing agreements have also been reached with the World Bank for health sector loans in Senegal and Mauritania.

50. A greater concentration of efforts will be required in order to develop these good beginnings into a broad alliance for support to the revitalization of basic health systems across Africa. As bilateral donors become increasingly involved in co-financing with the World Bank, the potential to have all major donors involved in each country becomes more real. In addition, considerable work in 1992 has been done with the WHO drug action programme in testing drug quality and in assessing drug management systems in selected developing countries. The September 1992 meeting of the African regional office of WHO on community health has provided a fresh focus on the Initiative to help this process.

51. Along with closer collaboration with the World Bank and WHO, one way for UNICEF to move forward to achieve the acceleration of the Initiative will be to develop specific agreements with bilateral donors. The first such agreement has been finalized with GTZ, which supports projects with financing derived mostly from the Government of Germany. This could pave the way for a series of other agreements on collaboration in countries of mutual interest.